Pain control often enables rehabilitation, greater socialization and activity involvement.

Examples	Pain Frequency	Pain Intensity
Mrs. G, a resident with poor short-and-long term memory and moderately impaired cognitive function asked the charge nurse for "a pill to make my aches and pains go away" once a day during the last 7 days. The medication record shows that she received Tylenol every evening. The charge nurse states that Mrs. G usually rubs her left hip when she asks for a pill. However, when you ask her about pain, Mrs. G tells you that she is fine and never has pain. ***Rationale for coding***: It appears that Mrs. G has forgotten that she has reported having pain during the last 7 days. Best clinical judgement calls for coding that reflects that Mrs. G has mild, daily pain.	2	1
Mr. T is cognitively intact. He is up and about and involved in self-care, social and recreational activities. During the last week he has been cheerful, engaging and active. When checked by staff at night, he appears to be sleeping. However, when you ask him how he's doing, he tells you that he has been having horrible cramps in his legs every night. He's only been resting, but feels tired upon arising. ***Rationale for coding***: Although Mr. T may look comfortable to staff, he reports to you that he has terrible cramps. Best clinical judgement for coding this "screening" item for pain would be to record codes that reflect what Mr. T tells you. It is highly likely that Mr. T warrants a further evaluation.	2	3

3. Pain Site

Intent: To record the location of physical pain as described by the resident, or discerned from objective physical and laboratory tests. Sometimes is difficult to pinpoint the exact site of pain, particularly if the resident is unable to describe the quality and location of pain in detail. Likewise, it will be difficult to pinpoint the exact site if the resident has not had physical or laboratory tests to evaluate the pain. In order to begin to develop a responsive care plan for

promoting comfort, the intent of this item is to help residents and caregivers begin a pain evaluation by attempting to target the site of pain.

Definition: **Back pain** — Localized or generalized pain in any part of the neck or back.

Bone pain — Commonly occurs in metastatic disease. Pain is usually worse during movement but can be present at rest. May be localized and tender but may also be quite vague.

Chest pain while doing usual activities — The resident experiences any type of pain in the chest area, which may be described as burning, pressure, stabbing, vague discomfort, etc. "Usual activities" are those that the resident engages in normally. For example, the resident's usual activities may be limited to minor participation in dressing and grooming, short walks from chair to toilet room.

Headache — The resident regularly complains or shows evidence (clutching or rubbing the head) of headache.

Hip pain — Pain localized to the hip area. May occur at rest or with physical movement.

Incisional pain — The resident complains or shows evidence of pain at the site of a recent surgical incision.

Joint pain (other than hip) — The resident complains or shows evidence of discomfort in one or more joints either at rest or with physical movement.

Soft tissue pain — Superficial or deep pain in any muscle or non-bony tissue. Examples include abdominal cramping, rectal discomfort, calf pain, wound pain.

Stomach Pain — The resident complains or shows evidence of pain or discomfort in the left upper quadrant of the abdomen.

Other — Includes either localized or diffuse pain of any other part of the body. Examples include general "aches and pains," etc.

Process: Ask the resident and observe for signs of pain. Consult staff members. Review the clinical record. Use your best clinical judgement.

Coding: Check all that apply during the last 7 days. If the resident has mouth pain check item K1c in Section K, "Oral/Nutritional Status."

4. Accidents

Intent: To determine the resident's risk of future falls or injuries. Falls are a common cause of morbidity and mortality among elderly nursing home residents. Residents who have sustained at least one fall are at risk of future falls. About half of all residents fall each year, with serious injury resulting from 6 to 10 percent of falls. Hip fractures account for approximately one-half of all serious injuries.

Definition: **Fell** — Note time frames (past 30 days and past 31-180 days).

Hip fracture in last 80 days — Note time frame (last 180 days).

Other fracture in last 180 days — Any fracture other than a hip fracture. Note time frame (last 180 days).

Process: **New admissions** — Consult with the resident and the resident's family. Review transfer documentation.

Current residents — Review the resident's records (including incident reports, current nursing care plan, and monthly summaries). Consult with the resident. Sometimes, a resident will fall, and believing that he or she "just tripped," will get up and not report the event to anyone. Therefore, do not rely solely on the clinical records but also ask the resident directly if he or she has fallen during the indicated time frame.

Coding: Check all conditions that apply. If no conditions apply, check *NONE OF ABOVE.*

5. Stability of Conditions

Intent: To determine if the resident's disease or health conditions present over the last seven days are acute, unstable, or deteriorating.

Definition: **Fluctuating, precarious, deteriorating** — Denotes the changing and variable nature of the resident's condition. For example, a resident may experience a variable response to the intensity of pain and the analgesic effect of pain medications. On "good days" over the last seven days, he or she will participate in ADLs, be in a good mood, and enjoy preferred leisure activities. On "bad days," he or she will be dependent on others for care, be agitated, cry, etc. Likewise, this category reflects the degree of difficulty in achieving a balance between treatments for multiple conditions.

Acute episode — Resident is symptomatic for an acute health condition (e.g., new myocardial infarction; adverse drug reaction; influenza), a recurrent (acute) condition (e.g., aspiration pneumonia; urinary tract infection) or an acute phase of a chronic disease (e.g., shortness of breath, edema, and confusion in a resident with congestive heart disease; acute joint pain and swelling in a resident who has had arthritis for many years). An acute episode is usually of sudden onset, has a time-limited course, requires physician evaluation and a significant increase in licensed nursing monitoring.

End-stage disease — In one's best clinical judgement, the resident with any end-stage disease has only six or fewer months to live. This judgment should be substantiated by a well documented disease diagnosis and deteriorating clinical course.

Process: Observe the resident. Consult staff members, especially the resident's physician. Review the resident's clinical record.

Coding: Check all that apply during last seven days. If none apply, check *NONE OF ABOVE.*

Examples

Mrs. M is diabetic. She requires daily or more frequent blood sugar tests in conjunction with administering sliding-scale insulin dosages. She has been confused on one occasion in the past week when she was hypoglycemic. **Check "a" for unstable — fluctuating, precarious, or deteriorating.**

If Mrs. M (above) were also to have pneumonia and fever during her assessment period, **check "a" for unstable and "b" for acute.**

Ms. F had been doing well and was ready for discharge to her apartment in elderly housing until she came down with the flu. Currently she has a low grade fever, general aches and pains, and respiratory symptoms of productive cough and nasal congestion. Although she has taken to bed for a few days she has had no change in ADL function, mood, etc. and is looking forward to discharge in a few days. **Check "b" for acute.**

Mrs. T was admitted to the unit with a diagnosis of chronic congestive heart failure. During the past few months she has had 3 hospital admissions for acute CHF. Her heart has become significantly weaker despite maximum treatment with medications and oxygen. Her physician has discussed her deteriorating condition with her and her family and has documented that her prognosis for survival in the next couple of months is poor. **Check "c" for end-stage disease.**

(continued on next page)

Examples
(continued)

Mr. R is a diabetic who receives a daily dose of NPH insulin 20 units sc QAM. He requires only monthly blood sugar determinations for follow-up, and has no current acute illness. Check "d" for *NONE OF ABOVE.*

SECTION K.
ORAL/NUTRITIONAL STATUS

1. Oral Problems

Intent: To record any oral problems present in the last seven days.

Definition: **Chewing problem** — Inability to chew food easily and without pain or difficulties, regardless of cause (e.g., resident uses ill-fitting dentures, or has a neurologically impaired chewing mechanism, or has temporomandibular joint pain, or a painful tooth).

Swallowing problem — Dysphagia. Clinical manifestations include frequent choking and coughing when eating or drinking, holding food in mouth for prolonged periods of time, or excessive drooling.

Mouth pain — Any pain or discomfort associated with any part of the mouth, regardless of cause. Clinical manifestations include favoring one side of the mouth while eating, refusing to eat, refusing food or fluids of certain temperatures (hot or cold).

Process: Ask the resident about difficulties in these areas. Observe the resident during meals. Inspect the mouth for abnormalities that could contribute to chewing or swallowing problems or mouth pain.

Coding: Check all that apply. If none apply, check *NONE OF ABOVE.*

2. Height and Weight

Intent: To record a current height and weight in order to monitor nutrition and hydration status over time; also, to provide a mechanism for monitoring stability of weight over time. For example, a resident who has had edema can

have an intended and expected weight loss as a result of taking a diuretic. Or weight loss could be the result of poor intake, or adequate intake accompanied by recent participation in a fitness program.

a. Height

Process: New admissions — Measure height in inches.

Current resident — Check the clinical records. If the last height recorded was more than one year ago, measure the resident's height again.

Coding: Round height upward to nearest whole inch. Measure height consistently over time in accord with standard facility practice (shoes off, etc.)

b. Weight

Process: Check the clinical records. If the last recorded weight was taken more than one month ago or weight is not available, weigh the resident again. If the resident's weight was taken more than once during the preceding month, record the most recent weight.

Coding: Round weight upward to the nearest whole pound. Measure weight consistently over time in accord with standard facility practice (after voiding, before meal, etc.).

3. Weight Change

Intent: To record variations in the resident's weight over time.

a. Weight Loss

Definition: Weight loss in percentages (e.g., 5% or more in last 30 days, or 10% or more in last 180 days).

Process: New admission — Ask the resident or family about weight changes over the last 30 and 180 days. Consult physician, review transfer documentation and compare with admission weight. Calculate weight loss in percentages during the specified time periods.

Current resident — Review the clinical records and compare current weight with weights of 30 and 180 days ago. Calculate weight loss in percentages during the specified time periods.

Coding: Code "0" for No or "1" for Yes. If there is no weight to compare to, enter NA or a circled dash ⊖.

b. Weight Gain

Definition: **Weight gain in percentages** (i.e., 5% or more in last 30 days, or 10% or more in last 180 days).

Process: **New admission** — Ask the resident or family about weight changes over the last 30 and 180 days. Consult physician, review transfer documentation and compare with admission weight. Calculate weight gain during the specified time periods.

Current resident — Review the clinical records and compare current weight with weights of 30 and 180 days ago. Calculate weight gain during the specified time periods.

Coding: Code "0" for No or "1" for Yes. If there is no weight to compare to, enter NA or a circled dash ⊖ .

4. Nutritional Problems

Intent: To identify specific problems, conditions, and risk factors for functional decline present in the last seven days that affect or could affect the resident's health or functional status. Such problems can often be reversed and the resident can improve.

Definition: **Complains about the taste of many foods** — The sense of taste can change as a result of health conditions or medications. Also, complaints can be culturally based — e.g., someone used to eating spicy foods may find nursing home meals bland.

Regular or repetitive complaints of hunger — On most days (at least 2 out of 3), resident asks for more food or repetitively complains of feeling hungry (even after eating a meal).

Leaves 25% or more of food uneaten at most meals — Eats less than 75 percent of food (even when substitutes are offered) at least 2 out of 3 meals a day.

Process: Consult resident's records (including current nursing care plan), dietary/fluid intake flow sheets, dietary progress notes/assessments. Consult with direct-care staff and consulting dietician. Ask the resident if he or she experienced

any of these symptoms in the last seven days. Sometimes a resident will not complain to staff members because he or she attributes symptoms to "old age." Therefore, it is important to ask the resident directly. Observe the resident while eating. If he or she leaves food or picks at it, ask "Why are you not eating?" Note if resident winces or makes faces while eating.

Coding: Check all conditions that apply. If no conditions apply, check *NONE OF ABOVE.*

5. Nutritional Approaches

Definition: **Parenteral/IV** — Intravenous (IV) fluids or hyperalimentation given continuously or intermittently. This category also includes administration of fluids via IV lines with fluids running at KVO (keep vein open), or via heparin locks. This category does not include administration of IV medications. If the resident receives IV medications, check item P1c in "Special Treatments and Procedures".

Feeding tube — Presence of any type of tube that can deliver food/nutritional substances/fluids/medications directly into the gastrointestinal system. Examples include, but are not limited to, nasogastric tubes, gastrostomy tubes, jejunostomy tubes, percutaneous endoscopic gastrostomy (PEG) tube.

Mechanically altered diet — A diet specifically prepared to alter the consistency of food in order to facilitate oral intake. Examples include soft solids, pureed foods, ground meat. Diets for residents who can only take liquids that have been thickened to prevent choking are also included in this definition.

Syringe (oral feeding) — Use of syringe to deliver liquid or pureed nourishment directly into the mouth.

Therapeutic diet — A diet ordered to manage problematic health conditions. Examples include calorie-specific, low-salt, low-fat lactose, no added sugar, and supplements during meals.

Dietary supplement between meals — Any type of dietary supplement provided between scheduled meals (e.g., high protein/calorie shake, or 3 p.m. snack for resident who receives q.a.m. dose of NPH insulin). Do not include snacks that everyone receives as part of the unit's daily routine.

Plate guard, stabilized built-up utensils, etc. — Any type of specialized, altered, or adaptive equipment to facilitate the resident's involvement in self-performance of eating.

On planned weight change program — Resident is receiving a program of which the documented purpose and goal are to facilitate weight gain or loss (e.g., double portions; high calorie supplements; reduced calories; 10 grams fat).

Coding: Check all that apply. If none apply, check *NONE OF ABOVE.*

6. Parenteral or Enteral Intake — Skip to Section L if neither item K5a nor K5b is checked.

Intent: To record the proportion of calories received, and the average fluid intake, through parenteral or tube feeding in the last seven days.

a. CALORIE INTAKE

Definition: **Proportion of total calories received** — the proportion of all calories during the last seven days ingested that the resident actually received (not ordered) by parenteral or tube feedings. Determined by calorie count.

Process: Review Intake record. If the resident took no food or fluids by mouth, or took just sips of fluid, stop here and code "4" (76%-100%). If the resident had more substantial oral intake than this, consult with the dietician who can derive a calorie count received from parenteral or tube feedings.

Coding: **Code for the best response.**

0. None
1. 1% to 25%
2. 26% to 50%
3. 51% to 75%
4. 76% to 100%

Example of Calculation for Proportion of Total Calories from IV or Tube Feeding

Mr. H has had a feeding tube since his surgery. He is currently more alert, and feeling much better. He is very motivated to have the tube removed. He has been taking soft solids by mouth, but only in small to medium amounts. For the past week he has been receiving tube feedings for nutritional supplementation. As his oral intake improves, the amount received by tube will decrease. The dietician has totalled his calories per day as follows:

Step #1:	Oral		Tube
Sun.	500	+	2000
Mon.	250	+	2250
Tues.	250	+	2250
Wed.	350	+	2250
Thurs.	500	+	2000
Fri.	800	+	1800
Sat.	800	+	1800
TOTAL	3450	+	14350

Step #2: Total calories = 3450 + 14350 = 17800

Step #3: Calculate percentage of total calories by tube feeding.

$\frac{14350}{17800} \times \frac{x}{100}$ [multiply total tube amount by 100, then divide by total calories]

1435000 divided by 17800 = 80.6% of total calories received by tube.

Step #4: **Code "4" for 76% to 100%**

b. AVERAGE FLUID INTAKE

Definition: Average fluid intake per day by IV or tube feeding in last seven days refers to the actual amount of fluid the resident received by these modes (not the amount ordered).

Process: Review the Intake and Output record from the last seven days. Add up the total amount of fluid received each day by IV and/or tube feedings only. Divide the week's total fluid intake by 7. This will give you the average of fluid intake per day.

Coding: Code for the average number of cc's of fluid the resident received per day by IV or tube feeding.

Codes:
0. None
1. 1 to 500 cc/day
2. 501 to 1000 cc/day
3. 1001 to 1500 cc/day
4. 1501 to 2000 cc/day
5. 2001 to or more cc/day

Example of Calculation for Average Daily Fluid Intake

Ms. A has swallowing difficulties secondary to Huntington's disease. She is able to take oral fluids by mouth with supervision, but not enough to maintain hydration. She received the following daily fluid totals by supplemental tube feedings (including water, prepared nutritional supplements, juices) during the last 7 days.

Step #1:

Sun.	1250 cc
Mon.	775 cc
Tues.	925 cc
Wed.	1200 cc
Thurs.	1200 cc
Fri.	1200 cc
Sat.	1000 cc
TOTAL	7550

Step #2:
7550 divided 7 = 1078.6 cc

Step #3:
Code "3" for 1001 to 1500 cc/day

SECTION L.
ORAL/DENTAL STATUS

1. Oral Status and Disease Prevention

Intent: To document the resident's oral and dental status as well as any problematic conditions.

Definition: Carious — Pertains to tooth decay and disintegration (cavities).

Process: Ask the resident, and examine the resident's mouth. Ask direct care staff if they have noticed any problems. Review the clinical record.

Coding: Check all that apply. If none apply, check *NONE OF ABOVE.*

SECTION M.
SKIN CONDITION

To determine the condition of the resident's skin, identify the presence, stage, type, and number of ulcers, and document other problematic skin conditions. Additionally, to document any skin treatments for active conditions as well as any protective or preventive skin or foot care treatments the resident has received in the last seven days.

1. Ulcer (due to any cause)

Intent: To record the number of ulcers, of any type at each ulcer stage, on any part of the body.

Definition: Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.

Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.

Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues. Presents as a deep crater with or without undermining adjacent tissue.

Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.

Process: Review the resident's record and consult with the nurse assistant about the presence of an ulcer. Examine the resident and determine the stage and number of any ulcers present. Without a full body check, an ulcer can be missed.

Assessing a Stage 1 ulcer requires a specially focused assessment for residents with darker skin tones to take into account variations in ebony-colored skin. To recognize Stage 1 ulcers in ebony complexions, look for: (1) any change in the feel of the tissue in a high-risk area; (2) any change in the appearance of the skin in high-risk areas, such as the "orange-peel" look; (3) a subtle purplish hue; and (4) extremely dry, crust-like areas that, upon closer examination, are found to cover a tissue break.

Coding: Record the number of ulcers at each stage on the resident's body, in the last 7 days, regardless of the ulcer cause. If necrotic eschar is present, prohibiting accurate staging, code the ulcer as Stage "4" until the eschar has been debrided (surgically or mechanically) to allow staging. If there are no ulcers at a particular stage, record "0" (zero) in the box provided. If there are more than 9 ulcers at any one stage, enter "9" in the appropriate box.

Example

Mrs. L has end-stage metastatic cancer and weighs 75 pounds. She has a Stage 3 ulcer over her sacrum and two Stage 1 ulcers over her heels.

Stage	Code
a. 1	2
b. 2	0
c. 3	1
d. 4	0

2. Type of Ulcer

Intent: To record the highest stage for two types of ulcers, Pressure and Stasis, that were present in the last 7 days.

Definition: Pressure ulcer — Any lesion caused by pressure resulting in damage of underlying tissues. Other terms used to indicate this condition include bed sores and decubitus ulcers.

Stasis ulcer — An open lesion, usually in the lower extremities, caused by decreased blood flow from chronic venous insufficiency; also referred to as a venous ulcer or ulcer related to peripheral vascular disease (PVD).

Process: Review the resident's record. Consult with the physician regarding the cause of the ulcer(s).

Coding: Using the ulcer staging scale in item M1 record the highest ulcer stage for pressure and stasis ulcers present in the last 7 days. Remember that there are other types of ulcers than the two listed in this item (e.g., ischemic ulcers). An ulcer recorded in item M1 may not necessarily be recorded in item M2. (See last example below).

Example

Mr. C has diabetes and poor circulation to his lower extremities. Last month Mr. C spent 2 weeks in the hospital where he had a left below the knee amputation (BKA) for treatment of a gangrenous foot. His hospital course was complicated by delirium (acute confusion) and he spent most of his time on bedrest. Nurses remarked that he would only stay lying on his back. He had only an eggcrate mattress on his bed to relieve pressure. A water mattress and air mattress were both tried but aggravated his agitation. He was readmitted to the nursing home 3 days ago with a Stage II pressure ulcer over his sacrum and a Stage I pressure ulcer over his right heel and both elbows. No other ulcers were present.

Type of Ulcer	Code (highest stage)
a. Pressure ulcer	2
b. Stasis ulcer	0

***Rationale for coding*:** Mr. C has 4 pressure ulcers, the highest stage of which is Stage 2.

Mrs. B has a blockage in the arteries of her right leg causing impaired arterial circulation to her right foot (ischemia). She has only 1 ulcer, a Stage 3 ulcer on the dorsal surface (top) of her right foot.

Type of Ulcer	Code (highest stage)
a. Pressure ulcer	0
b. Stasis ulcer	0

***Rationale for coding*:** Mrs. B's ulcer is an ischemic ulcer rather than caused by pressure or venous stasis.

3. History of Resolved/Cured Ulcers

Intent: To determine if the resident previously had an ulcer that was resolved or cured during the past 90 days. Identification of this condition is important because it is a risk factor for development of subsequent ulcers.

Process: Review clinical records, including the last Quarterly Assessment

Coding: Code "0" for No or "1" for Yes.

4. Other Skin Problems or Lesions Present

Intent: To document the presence of skin problems other than ulcers, and conditions that are risk factors for more serious problems.

Definition: **Abrasions, bruises** — Includes skin scrapes, ecchymoses, localized areas of swelling, tenderness and discoloration.

Burns (second or third degree) — Includes burns from any cause (e.g., heat, chemicals) in any stage of healing. This category does not include first degree burns (changes in skin color only).

Rashes — Includes inflammation or eruption of the skin that may include change in color, spotting, blistering, etc. and symptoms such as itching, burning, or pain. Record rashes from any cause (e.g., heat, drugs, bacteria, viruses, contact with irritating substances such as urine or detergents; allergies, etc.). Intertrigo refers to rashes (dermatitis) within skin folds.

Skin desensitized to pain or pressure — The resident is unable to perceive sensations of pain or pressure.

Review the resident's record for documentation of impairment of this type. An obvious example of a resident with this problem is someone who is comatose. Other residents at high risk include those with quadriplegia, paraplegia, hemiplegia or hemiparesis, peripheral vascular disease and neurological disorders. In the absence of documentation in the clinical record, sensation can be tested in the following way:

- To test for pain, use a new, disposable safety pin or wooden "orange stick" (usually used for nail care). Always dispose of the pin or stick after each use to prevent contamination.

- Ask the resident to close his or her eyes. If the resident cannot keep his or her eyes closed or cannot follow directions to close eyes, block what you are doing (in local areas of legs and feet) from view with a cupped hand or towel.

- Lightly press the pointed end of the pin or stick against the resident's skin. Do not press hard enough to cause pain, injury, or break in the skin. Use the pointed and blunt ends of the pin or stick alternately to test sensations on the resident's arms, trunk, and legs. Ask the resident to report if the sensation is "sharp" or "dull."

- Compare the sensations in symmetrical areas on both sides of the body.

- If the resident is unable to feel the sensation, or cannot differentiate sharp from dull, the area is considered desensitized to pain sensation.

- For residents who are unable to make themselves understood or who have difficulty understanding your directions, rely on their facial expressions (e.g., wincing, grimacing, surprise), body motions (e.g., pulling the limb away, pushing the examiner) or sounds (e.g., "Ouch!") to determine if they can feel pain.

- Do not use pins with agitated or restless residents. Abrupt movements can cause injury.

Skin tears or cuts (other than surgery) — Any traumatic break in the skin penetrating to subcutaneous tissue. Examples include skin tears, lacerations, etc.

Surgical wounds — Includes healing and non-healing, open or closed surgical incisions, skin grafts or drainage sites on any part of the body. This category does not include healed surgical sites or stomas.

Process: Ask the resident if he or she has any problem areas. Examine the resident. Ask nurse assistant. Review the resident's record.

Coding: Check all that apply. If there is no evidence of such problems in the last seven days, check *NONE OF ABOVE.*

5. Skin Treatments

Intent: To document any specific or generic skin treatments the resident has received in the past seven days.

Definition: **Pressure relieving device(s) for chair** — Includes gel, air (e.g., Roho), or other cushioning placed on a chair or wheelchair. Do not include egg crate cushions in this category.

Pressure relieving device(s) for bed — Includes air fluidized, low airloss therapy beds, flotation, water, or bubble mattress or pad placed on the bed. Do not include egg crate mattresses in this category.

Turning/repositioning program — Includes a continuous, consistent program for changing the resident's position and realigning the body.

Nutrition or hydration intervention to manage skin problems — Dietary measures received by the resident for the purpose of preventing or treating specific skin conditions — e.g., wheat-free diet to prevent allergic dermatitis, high calorie diet with added supplements to prevent skin breakdown, high protein supplements for wound healing.

Ulcer care — Includes any intervention for treating an ulcer at any ulcer stage. Examples include use of dressings, chemical or surgical debridement, wound irrigations, and hydrotherapy.

Surgical wound care — Includes any intervention for treating or protecting any type of surgical wound. Examples of care include topical cleansing, wound irrigation, application of antimicrobial ointments, dressings of any type, suture removal, and warm soaks or heat application.

Application of dressings (with or without topical medications) other than to feet — Includes dry gauze dressings, dressings moistened with saline or other solutions, transparent dressings, hydrogel dressings, and dressings with hydrocolloid or hydroactive particles.

Application of ointments/medications (other than to feet) — Includes ointments or medications used to treat a skin condition (e.g., cortisone, antifungal preparations, chemotherapeutic agents, etc.). This definition does not include ointments used to treat non-skin conditions (e.g., nitropaste for chest pain).

Other preventative or protective skin care (other than to feet) — Includes application of creams or bath soaks to prevent dryness, scaling; application of protective elbow pads (e.g., down, sheepskin, padded, quilted).

Process: Review the resident's records. Ask the resident and nurse assistant.

Coding: Check all that apply. If none apply in the past seven days, check *NONE OF ABOVE*

6. Foot Problems and Care

Intent: To document the presence of foot problems and care to the feet during the last seven days.

Definition: **Open lesions on the foot** — Includes cuts, ulcers, fissures.

Nails or callouses trimmed during the last 90 days — Pertains to care of the feet. Includes trimming by nurse or any health professional, including a podiatrist.

Received preventative or protective foot care — Includes any care given for the purpose of preventing skin problems on the feet, such as diabetic foot care, foot soaks, protective booties (e.g., down, sheepskin, padded, quilted), special shoes, orthotics, application of toe pads, toe separators, etc.

Application of dressings with or without topical medications — Includes dry gauze dressings, dressings moistened with saline or other solutions, transparent dressings, hydrogel dressings, and dressings with hydrocolloid or hydroactive particles.

Process: Ask the resident and nurse assistant. Inspect the resident's feet. Review the resident's clinical records.

Coding: Check all that apply. If none apply in the past seven days, check *NONE OF ABOVE*

SECTION N.
ACTIVITY PURSUIT PATTERNS

Intent: To record the amount and types of interests and activities that the resident currently pursues; as well as activities the resident would like to pursue that are not currently available at the facility.

Definition: Activity pursuits. Refers to any activity other than ADLs that a resident pursues in order to enhance a sense of well-being. These include activities that

provide increased self-esteem, pleasure, comfort, education, creativity, success, and financial or emotional independence.

1. Time Awake

Intent: To identify those periods of a typical day (over the last seven days) when the resident was awake all or most of the time (i.e., no more than one hour nap during any such period). For careplanning purposes this information can be used in at least two ways:

- The resident who is awake most of the time could be encouraged to become more mentally, physically, and/or socially involved in activities (solitary or group).
- The resident who naps a lot may be bored or depressed and could possibly benefit from greater activity involvement.

Process: Consult with direct care staff, the resident, and the resident's family.

Coding: Check all periods when resident was awake all or most of the time. Morning is from 7 am (or when resident wakes up, if earlier or later than 7 am) until noon. Afternoon is from noon to 5 pm. Evening is from 5 pm to 10 pm (or bedtime, if earlier). **If resident is comatose, this is the only Section N item to code, skip all other Section N items and go to Section O.**

2. Average Time Involved in Activities

Intent: To determine the proportion of available time that the resident was actually involved in activity pursuits as an indication of his or her overall activity-involvement pattern. This time refers to free time when the resident was awake and was not involved in receiving nursing care, treatments, or engaged in ADL activities and could have been involved in activity pursuits and Therapeutic Recreation.

Process: Consult with direct care staff, activities staff members, the resident, and the resident's family. Ask about time involved in different activity pursuits.

Coding: In coding this item, exclude time spent in receiving treatments (e.g., medications, heat treatments, bandage changes, rehabilitation therapies, or ADLs). Include time spent in pursuing independent activities (e.g., watering plants, reading, letter-writing); social contacts (e.g., visits, phone calls) with family,

other residents, staff, and volunteers; recreational pursuits in a group, one-on-one or an individual basis; and involvement in Therapeutic Recreation.

3. Preferred Activity Settings

Intent: To determine activity circumstances/settings that the resident prefers, including (though not limited to) circumstances in which the resident is at ease.

Process: Ask the resident, family, direct care staff, and activities staff about the resident's preferences. Staff's knowledge of observed behavior can be helpful, but only provides part of the answer. Do not limit preference list to areas to which the resident now has access, but try to expand the range of possibilities for the resident.

Example

Ask the resident, "Do you like to go outdoors? Outside the facility (to a mall)? To events downstairs?" Ask staff members to identify settings that resident frequents or where he or she appears to be most at ease.

Coding: Check all responses that apply. If the resident does not wish to be in any of these settings, check *NONE OF ABOVE.*

4. General Activity Preferences (adapted to resident's current abilities)

Intent: Determine which activities of those listed the resident would prefer to participate in (independently or with others). Choice should not be limited by whether or not the activity is currently available to the resident, or whether the resident currently engages in the activity.

Definition: **Exercise/sports** — Includes any type of physical activity such as dancing, weight training, yoga, walking, sports (e.g., bowling, croquet, golf, or watching sports).

Music — Includes listening to music or being involved in making music (singing, playing piano, etc.)

Reading/writing — Reading can be independent or done in a group setting where a leader reads aloud to the group or the group listens to "talking books." Writing can be solitary (e.g., letter-writing or poetry writing) or done as part of a group program (e.g., recording oral histories). Or a volunteer can record the thoughts of a blind, hemiplegic, or apraxic resident in a letter or journal.

Spiritual/religious activities — Includes participating in religious services as well as watching them on television or listening to them on the radio.

Gardening or plants — Includes tending one's own or other plants, participating in garden club activities, regularly watching a television program or video about gardening.

Talking or conversing — Includes talking and listening to social conversations and discussions with family, friends, other residents, or staff. May occur individually, in groups, or on the telephone; may occur informally or in structured situations.

Helping others — Includes helping other residents or staff, being a good listener, assisting with unit routines, etc.

Process: Consult with the resident, the resident's family, activities staff members, and nurse assistants. Explain to the resident that you are interested in hearing about what he or she likes to do or would be interested in trying. Remind the resident that a discussion of his or her likes and dislikes should not be limited by perception of current abilities or disabilities. Explain that many activity pursuits are adaptable to the resident's capabilities. For example, if a resident says that he used to love to read and misses it now that he is unable to see small print, explain about the availability of taped books or large print editions.

For residents with dementia or aphasia, ask family members about resident's former interests. A former love of music can be incorporated into the care plan (e.g., bedside audiotapes, sing-a-longs). Also observe the resident in current activities. If the resident appears content during an activity (e.g., smiling, clapping during a music program) check the item on the form.

Coding: Check each activity preferred. If none are preferred, check *NONE OF ABOVE.*

5. Prefers Change in Daily Routine

Intent: To determine if the resident has an interest in pursuing activities not offered at the facility (or on the nursing unit), or not made available to the resident. This includes situations in which an activity is provided but the resident would like to have other choices in carrying out the activity (e.g., the resident would like to watch the news on TV rather than the game shows and soap operas preferred by the majority of residents; or the resident would like a Methodist service rather than the Baptist service provided for the majority of residents). Residents who resist attendance/involvement in activities offered at the facility

are also included in this category in order to determine possible reasons for their lack of involvement.

Process: Review how the resident spends the day. Ask the resident if there are things he or she would enjoy doing (or used to enjoy doing) that are not currently available or, if available, are not "right" for him or her in their current format. If the resident is unable to answer, ask the same question of a close family member, friend, activity professional, or nurse assistant. Would the resident prefer slight or major changes in daily routines, or is everything OK?

Coding: For each of the items, code for the resident's preferences in daily routines using the codes provided.

0. **No change** — Resident is content with current activity routines.

1. **Slight change** — Resident is content overall but would prefer minor changes in routine (e.g., a new activity, modification of a current activity).

2. **Major change** — Resident feels bored, restless, isolated, or discontent with daily activities or resident feels too involved in certain activities, and would prefer a significant change in routine.

Example

Mrs. B is regularly involved in several small group activities. She also has expressed a preference for music. However, she has consistently refused to go to group sing-alongs when the activity staff offer to bring her. She says she doesn't like big groups and prefers to relax and listen to classical music in her room. She wishes she had a radio or tape player to do this.

		Code
a.	Type of activities in which resident is currently involved	1 (Slight change)
b.	Extent of resident involvement in activities.	1 (Slight change)

SECTION O. MEDICATIONS

1. Number of Medications

Intent: To determine the number of different medications (over-the-counter and prescription drugs) the resident has received in the past seven days.

Process: Count the number of different medications (not the number of doses or different dosages) administered by any route (e.g., oral, IV, injections, patch) at any time during the last seven days. Include any routine, prn, and stat doses given. "Medications" can also include topical preparations, ointments, creams used in wound care (e.g., Elase), eyedrops, vitamins, and suppositories. Include any medication that the resident administers to self, if known. If the resident takes both the generic and brand name of a single drug, count as only one medication. If the resident received a long-acting antipsychotic medication prior to the assessment period (e.g., if a fluphenazine deconoate or haloperidol deconoate is given once a month) count as one drug.

Coding: Write the appropriate number in the answer box. Count only those medications actually administered and received by the resident over the last seven days. Do not count medications ordered but not given.

Example

Resident was given Digoxin 0.25 mg po on Tuesday and Thursday and Digoxin 0.125 mg po on Monday, Wednesday, and Friday. Although the dosage is different for different days of the week, the medication is the same. **Code "1" (one medication received).**

2. New Medications

Intent: To record whether the resident is currently receiving medications that were initiated in the last 90 days.

Coding: Code "1" if the resident received (and continues to receive) new medications in the last 90 days. Code "0" if the resident did not receive any new medications in the past 90 days. If the resident received new medication(s) in the last 90 days but they were discontinued prior to this assessment period, code "0" (no new medication).

3. Injections

Intent: To determine the number of days during the past seven days that the resident received any type of medication, antigen, vaccine, by subcutaneous, intramuscular or intradermal injection. Although antigens and vaccines are considered "biologicals" and not medication per se, it is important to track when they are given to monitor for localized or systemic reactions. This category does not include intravenous (IV) fluids or medications. If the resident received IV fluids, record in Item K5a, Parenteral/IV. If IV medications were given, record in Item P1c, IV medications.

Coding: Record the number of DAYS in the answer box.

Example

During the last seven days, Mr. T received a flu shot on Monday, a PPD test (for tuberculosis) on Tuesday, a Vitamin B_{12} injection on Wednesday. **Code "3" for Resident received injections on three days during the last seven days.**

4. Days Received the Following Medication

Intent: To record the number of days that the resident received each type of medication listed (antipsychotics, antianxiety, antidepressants, hypnotics, diuretics) in the past seven days. See Appendix E for list of drugs by category. Includes any of these medications given to the resident by any route (po, IM, or IV) in any setting (e.g., at the nursing home, in a hospital emergency room).

Process: Review the resident's clinical record for documentation that a medication was received by the resident during the past seven days. In the case of a new admission, review transmittal records.

Coding: Enter the number of days each of the listed types of medications was received by the resident during the past seven days. In the case of a new admission, if it is clearly documented that the resident received any type of medication (listed in this item) at the sending facility, record the number of days each listed medication was received during the past seven days. If transmittal records are not clear or do not reference that the resident received one of these medications, record "0" (not used) in the corresponding box. If the resident did not use any medications from a drug category, enter "0". If the resident uses long-lasting drugs that are taken less often than weekly (e.g., Prolixin (Fluphenazine deconoate) or Haldol (Haloperidol deconoate) given every few weeks or monthly) enter "1."

Example 1

Medication Record for Mrs. P

- Haldol 0.5 mg po BID p.r.n.: Received once a day on Monday, Wednesday, and Thursday [Note: Haldol = Antipsychotic drug]
- Ativan 1 mg po QAM: Received every day [Note: Ativan = Antianxiety drug]
- Restoril 15 mg po QHS p.r.n.: Received at H.S. on Tuesday and Wednesday only [Note: Restoril = Hypnotic]
- Mrs. P became severely short of breath in the middle of the night during the last seven days. She was transferred (but not admitted) to the emergency room (ER) at the local hospital. Upon her return to the nursing home the ER transmittal record stated that she had received 1 dose of IV Lasix [Note: Lasix = Diuretic].

Coding

Medication	No. of days received
a. Antipsychotic:	"3" (days)
b. Antianxiety:	"7" (days)
c. Antidepressant:	"0" (days)
d. Hypnotic:	"2" (days)
e. Diuretic:	"1" (days)